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11. IMPLEMENTATION PLAN FOR SERVICES TO AMERICAN INDIANS

Introduction

This section describes the implementation plan for the delivery of services for American Indians. The State of Oklahoma has worked with the tribes and IHS since the summer of 1994 to develop components of the program which effectively address the needs of American Indian clients and tribal, urban Indian and IHS providers.

During a number of meetings conducted during the last half of 1994, three features were repeatedly identified which were felt by participants at the various meetings to be essential in a managed care program. These included: 1) mechanisms for ensuring that IIIS, tribal and urban Indian programs operating under contract to IHS receive appropriate Medicaid reimbursement; **2)** continued ability for Indian clients to obtain services in both Indian programs and through the non-Indian provider system, as is currently possible; and, 3) provisions which would give Indian providers the option to participate either as Health Plan network providers or fee-for-service providers, whenever possible, at their option. For example, in some circumstances, tribal or urban Indian providers might be willing to operate as Health Plan providers at a capitated rate to increase their volume of patients.

During a meeting which was held at the Creek Nation on November 16, 1995 for all tribes, urban Indian clinic representatives and IHS personnel, specific provisions related to American Indians for the State's 1115(a) application were developed. These provisions incorporated the elements described above. In addition, meeting participants were instrumental in developing actual language used in the application.

A meeting was held in Oklahoma City on October 6, 1995 to give the State the opportunity to consult with tribal, IHS and urban Indian clinic representatives in development of the State's implementation plan for managed care service delivery to American Indians. During that meeting, issues were identified that should be considered in implementing the new system and strategies for implementation were addressed. In addition, a 16-member task force, the Oklahoma Indian Health Reform Committee, was created to act as a liaison from the tribes to the State in developing the current plan and in designing future components of the system.

During the weeks after the October 6 meeting, the State provided meeting participants with ongoing drafts of the plan and participants responded with comments. The State attended a meeting of the Committee in Wewoka, Oklahoma on October 23, 1995 to review the draft. Finally, a meeting was held on October 27, 1995 in Oklahoma City for participants from the earlier meeting to begin to finalize the plan. Over the next week the Committee developed its final recommendations and transmitted them to the State by facsimile on November 2,1995.

A memorandum was sent to the Committee on November 3,1995 with a copy of the final draft of the implementation plan which discusses a few features recommended by Committee members which the State did not feel it could include in the program (see attachment). However, the final implementation plan incorporates both initial collaboration with the tribes and most of

the recommendations of the tribes and the Committee. The next sections describe the State's plan for delivering services to American Indians under the State's 1115(a) demonstration as it was developed through this process.

Urban System

Overview

The State of Oklahoma is currently operating a Medicaid managed care program in the three largest metropolitan areas of the State under a 1915(b) waiver. The State will begin delivery of managed care health services under a statewide 1115(a) waiver. A number of provisions of Health Plan contracts in these areas address services to American Indians living in the urban areas. These provisions will continue under the 1115(a) demonstration, ***Soonercare.***

State legislation mandating development of a Statewide managed care system requires the Oklahoma Health Care Authority to implement a system in which three important goals are achieved. In order to reduce baseline expenditures and the rate of program inflation, the system must achieve cost containment. However, in order to ensure that efforts to contain costs do not sacrifice important public health priorities, the system also must enhance access and promote continuity of care for Title XIX recipients and improve quality of services.

The Oklahoma Medicaid program will be one of the first in the nation to require managed care Health Plans to comply fully with two federally-authorized quality assurance standards. The Quality Assurance Review Initiative (QARI) establishes extensive standards for program structure and operations. The Medicaid Healthplan Employer Data and Information Set (Medicaid HEDIS), which has been developed by a national **task** force and is currently nearing final approval, relies on encounter data to monitor and modify both health service process and outcomes.

In the ***SoonerCare*** program in urban areas, Title XIX beneficiaries, including American Indians, must enroll with a Health Plan. However, special provisions of the program, included in contracts with Health Plans, allow American Indian Title XIX beneficiaries to have unrestricted access to IHS, tribal or urban Indian providers, regardless of whether the provider is a member of the Health Plan's network. In addition, Plans are required to contract with all urban Indian providers within the respective service areas. Since both urban Indian clinics in the State are also FQHCs, contract provisions related to FQHCs also apply to the urban clinics, including provisions for risk-adjusted capitation rates or cost-related reimbursement of FQHCs by Health Plans. The State also intends to reimburse urban Indian FQHC providers using the cost-related methodology if they do not participate as Health Plan providers.

In July, 1996, the State will expand its Health Plan service areas to include regions of the State where an extensive system of tribal government health networks are located. At that time, Health Plans will be required to contract with tribal providers located in the expanded service areas. Federal law does not permit IHS facilities to contract with Health Plans for

capitation payments f the IHS provider assumes risk. However, the State is currently exploring with HCFA reimbursement mechanisms for effectively including IHS-operated facilities within Health Plan networks.

Tribes have expressed concern about liability issues related to participation as Health Plan network providers and Primary Care Physician/Case Managers. Presently, Federal tort coverage is extended to tribal providers under the provisions of P.L. 93-638, as amended. Liability issues should be carefully explored by IHS and tribal legal counsel, and legal recommendations should be given to IHS or tribes prior to their decisions about whether they will participate as providers. Specifically, there is concern that, while providers may be assuming risk for service delivery, they may not be covered by the Federal Tort Claims Act. Tribes are also concerned that contracts with the State or Health Plans not contain any express or implied waivers of sovereign immunity, unless a waiver is granted for the purposes of the contract by a specific resolution of the tribe.

As the State continues ongoing development of the Oklahoma Medicaid managed care system, it will do so in consultation with tribes, working through the Oklahoma Indian Health Reform Committee and with individual tribes in areas in which managed care services are being implemented. In addition, the State will continue collaboration with IHS and urban Indian providers.

Current Contract Provisions

Current contract provisions related to services for American Indians include:

Section 2.9.6.7

Each Health Plan must allow members who are Indian Health Service (IHS) beneficiaries to seek care from any IHS, tribal provider or urban Indian provider, whether or not the provider is part of the Health Plan's provider network. Health Plans may not prevent members who are IHS beneficiaries from seeking care from IHS, tribal or urban providers due to their status as American Indians. If an out-of-network IHS, tribal or urban Indian provider delivers services to Health Plan members, the State will reimburse the provider on a fee-for-service basis, as is currently done --for IHS facilities or federally-leased facilities, reimbursement will be at the Office of Management (OMB) rate; for other providers, services will be reimbursed at the prevailing Medicaid fee-for-service rate. The State will monitor the volume of services delivered to IHS beneficiaries out-of-network and will adjust aggregate Health Plan capitation rates in the next contract year to recapture the cost of this care.

Section 2.5.7.2.1

The Health Plan must allow any Health Plan member who is an American Indian the freedom to change Primary Care Physicians (PCPs) at any time if the member wishes to receive services from an IHS, urban or tribal provider serving as a PCP in the Health Plan's network.

Section 2.8.7.2

Each Health Plan must include providers in its network who have historically delivered a significant portion of their services to Title XIX clients (called traditional providers). Traditional providers must be included in sufficient numbers to reflect the cultural diversity and geographic distribution of the Medicaid population in a metropolitan region.

Section 2.8.7

Traditional providers for the urban areas include Federally Qualified Health Centers (FQHCs) and Urban Indian Health Center.

Health Plans under the demonstration will be required in most cases to contract with FQHCs, unless Plans provide documentation of their ability to deliver appropriate services without including FQHCs in their networks. Health Plans are currently required to contract with all IHS, tribal and urban Indian providers located in their service areas, if the providers desire to enter into contracts, at no less favorable terms and conditions as other providers in their nehvorks. Each Health Plan must also provide evidence, upon request, that it has negotiated in good faith with any traditional provider who sought to become a member of its network for purposes of serving Medicaid clients.

"Good faith negotiations" include:

Offering traditional providers the same participation terms, including reimbursement, as are offered by Contractor to other providers with equivalent scopes of practice or service. If requested by either party, a face-to-face meeting must have been held.

For FQHCs, agreeing to contract and reimburse for covered ancillary, dental, and pharmacy services, if provided by the center.

For Indian Health Service providers, urban Indian clinics under contract with the Indian Health Service, and tribal providers, also agreeing that these providers may restrict their participation in Contractor's network to providing services to IHS beneficiaries. IHS, tribal and urban Indian providers may elect to restrict participation to IHS beneficiaries.

Rural System

Beginning in July, 1996, Health Plans under contract to the State must expand their service areas to include areas of the State which serve rural Title XIX beneficiaries, including many American Indian clients. Health Plans will also receive special consideration in the bid selection process to the extent they have achieved significant linkages with rural areas of the State which are not being served by Health Plans. One way in which they may demonstrate effective linkages is if, at the request of a tribe, they significantly assist a tribal health program in the development, contract management, or tertiary referral/specialist component of a tribal managed care program serving American Indian Title XIX recipients.

The State is implementing a system of primary care physician/case management (PCP/CM) in areas of the State with insufficient providers and/or Title XIX clients to support fully-integrated Health Plans. In this system, American Indian Title XIX beneficiaries will enroll with a PCP/CM. However, as in the urban system, Indian clients will be able to obtain these services and non-capitated services from IHS, tribal or urban Indian providers without restrictions. Capitation adjustments will not be made against individual PCP/CM providers. Rather, as in the urban areas, the aggregate capitation rate for PCP/CMs will be adjusted downward in the next contract year to reflect out-of-network utilization. PCP/CM capitation adjustments will be made only for those services for which the PCP/CM was actually capitated --outpatient primary care visits, case management and a very limited package of laboratory and x-ray services which are normally provided during primary care office visits.

Tri-County Pilot ***Project***

Beginning on March 1, 1996, the State will establish a PCP/CM system in three contiguous pilot counties -- Hughes, Seminole and Okfuskee counties. This pilot program will operate for a three-month period prior to full implementation of the full statewide PCP/CM system. which will begin June 1, 1996. Implementation of a pilot project will allow the program to ensure that enrollment and information systems are operating at optimal efficiency when the full system is implemented approximately 90 days later. It will also facilitate the identification and resolution of potential problems prior to full enrollment.

These counties were selected based on a number of factors. In addition to other features, two American Indian tribes, the Muskogee Creek and Seminole tribes, have health facilities located within these counties. The Creek Nation operates a hospital in Okfuskee County, in the town of Okemah.

The State is currently beginning work with the tribes in the tri-county area to plan system development and strategies for implementation which are flexible and meet the unique needs of each tribe. The pilot project will enable the State to collaborate with tribes to conduct client outreach, to integrate tribal providers into the PCP/CM program if they desire to participate, and to ensure that mechanisms are in place to enable American Indian recipients to gain effective access to IHS, tribal and urban providers who are not participating in the PCP/CM system. Involvement of these tribes in the pilot project will be very important to the State as it addresses issues related to American Indians in preparation of implementation of the PCP/CM program into areas of the State served by other tribal and IHS health programs.

Education and Outreach

The State will develop education and outreach programs and materials for Indian beneficiaries and IHS, tribal and urban Indian providers in consultation with the tribes and urban Indian providers. The State will work with individual tribes to ensure that education and outreach effectively meets the needs of persons receiving services through specific tribal programs.

At the time of implementation of the 1115(a) demonstration. the State will conduct meetings with IHS and tribal health program administrators and their staffs to explain details of the program and special provisions for American Indians. Information will include procedures to be followed for referral of clients to non-IHS providers, delivery of emergency care and post-emergency referrals. and obtaining non-emergency transportation. The State will also provide written educational materials to IHS and tribal providers which describe the program. In addition. the State will include information for tribes about how their physicians may participate as PCP/CM providers. Information will also be provided to IHS, tribal and urban Indian providers regarding the rates which the State will pay to different provider types under both the fee-for-senice and managed care systems.

Currently in urban areas served by Health Plans, DHS case workers inform American Indians of their right to obtain services from out-of-network Indian programs at the time clients are seen at DHS county offices for Title XIX recertification and Health Plan enrollment. **A** brochure in the client enrollment packet which gives an overview of the ***SoonerCare*** program contains a description of these provisions. In addition, the State has developed a separate brochure describing provisions for American Indians in urban areas which is included in all enrollment packets (a copy of the brochure will be provided when printing is completed). At the time the PCP/CM system is implemented, a brochure describing services for American Indians in the rural areas will be included in all enrollment materials.

The Oklahoma Health Care Authority will **work** with DHS to ensure that the DHS case workers who conduct Title XIX certification and PCP/CM enrollment in rural areas understand provisions of the program under which IHS-eligible American Indian clients may seek services from Indian programs without restriction. The Authority will also ensure that workers are trained to educate American Indian clients who are either potentially eligible for Title XIX and making a certification application or already eligible for Medicaid about these provisions.

The State is making plans to modify its current enrollment video to alert American Indians to unique features of the program pertaining to them. A message will be added to the video instructing American Indians as to how they may learn about their special privilege. .nder ***SoonerCare***.

At the request of tribes, the Authority will provide educational forums for tribal representatives involved in outreach to Title XIX beneficiaries. Tribes have indicated an interest in conducting outreach through community and church meetings, through information made available at tribal health facilities and through articles in tribal publications.

Referrals from IHS/tribal and urban Indian providers
Contract Health Services

IHS is the payor of last resort after other payors, including Medicaid. Referrals to non-IHS providers from IHS/tribal and urban Indian providers may occur when services are not

available through the Indian provider. In some cases, Title XI?(-eligible American Indians will be referred to non-IHS providers for Contract Health Services (CHS). A number of issues of potential concern to IHS related to referrals and CHS have been identified.

Health services for IHS beneficiaries who have not been determined eligible for Title XIX prior to referral or who are not yet enrolled in managed care systems at the time referral is made will be reimbursed retrospectively through the fee-for-service system. IHS beneficiaries who are Medicaid-eligible and enrolled in Health Plans or with a PCP/CM prior to referral for CHS must be referred for services through their Health Plans or PCP/CMs. Services related to the referral will be coordinated by the Health Plan or the rural primary care provider, with input from the IHS, tribal or urban Indian provider as to the reason for which the referral was made. Health Plans and PCP/CMs will also be required to advise the IHS, tribal and urban Indian provider about the course of treatment of each referral. When a client is referred to a Health Plan or is receiving services through a CHS referral, their ability to obtain other services through-the Indian program will not be affected.

If clients self-refer for services without authorization from CHS or the Health Plan, Medicaid will not reimburse for services. In addition, since IHS does not normally pay for health services from contract non-IHS/tribal urban providers without authorization through Contract Health Services, CHS may also decline to reimburse.

The State is currently developing mechanisms to ensure that IHS, tribes and urban Indian providers will be able to determine Medicaid eligibility and Health Plan or PCP/CM enrollment.

Low-Term Planning/Models for Services to American Indians

The State is exploring with tribes a number of models which could be implemented through tribal health programs in future years of the demonstration. Through the availability of multiple models, tribes will have the flexibility to structure services which best need the needs of Title XIX beneficiaries served through their systems.

Several tribes have health networks which include both tribal inpatient hospitals and multiple outpatient clinics. Models which are being considered include fully-capitated tribal Health Plans. Implementation of this model would require provider network and fiscal solvency sufficient to gain State licensure as Health Maintenance Organizations. The State is also exploring development of sub-capitated, prepaid rural networks, licensed as prepaid health plans by the State, in which a tribe would coordinate all inpatient and outpatient primary care and specialty services available within their tribal health programs. Under this model, the tribal program would link with a Health Plan for tertiary services. IHS and tribal providers Several tribes have also expressed interest in developing multi-tribal integrated health delivery systems.

The State will work with the tribes to determine licensure requirements and provide technical assistance, if requested by the tribes. Because several tribes have expressed concern about

becoming licensed in order to implement integrated long-term care models, the State also will explore other mechanisms, such as compacting to deliver services. that might be used as alternatives (subject to any necessary changes to existing State law.

In addition to consultation with tribes and collaboration with IHS and urban Indian providers, the State will work with the Oklahoma Indian Health Reform Committee in development of long-term models. Any models developed that represent new types of managed care entities, also will be presented to HCFA for review and approval prior to their implementation.